VIRGINIA MEDICAID REQUEST FOR SERVICE AUTHORIZATION DUR MEDICATIONS ONFI™	COMMONWEALTH of VIRGINIA *Department of Medical Assistance Services*

Requests for service authorization (SA) must include patient name, Medicaid ID#, drug name, and appropriate clinical information to support the request on the basis of medical necessity. Please include all requested information; incomplete forms will delay the SA process. **SUBMISSION OF DOCUMENTATION DOES NOT GUARANTEE COVERAGE BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND FINAL COVERAGE DECISIONS MAY BE AFFECTED BY SPECIFIC MEDICAID LIMITATIONS.** The completed form may be **FAXED TO 800-932-6651**. Requests may be phoned to 800-932-6648 or mailed to:
Magellan Medicaid Administration / 11013 W. Broad St / Glen Allen, VA 23060 / ATTN: MAP
All questions must be answered

Today's Date: ___ ___/___ ___/___ ___ ___ ___   Requested Start Date: ___ ___/___ ___/___ ___ ___ ___

PATIENT INFORMATION

Name: (Last, First) _____   **Medicaid ID#:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___/___ ___/___ ___ ___ ___   **Gender:**   □ **Male**   □**Female**

DRUG INFORMATION

Drug Name, Dosage Form & Strength:	Quantity Per Day:

Onfi ™ (clobazam) to receive a **one year** SA for this drug please complete below

Is the patient using this as adjunctive treatment for seizures associated with Lennox-Gastaut syndrome (LGS)?   □ Yes   □ No

Is the patient 2 years of age or older?   □ Yes   □ No

Is the patient on other anticonvulsant(s) drugs?   □ Yes   □ No

List current medications:_____
_____
List previous medication failures:_____
_____
_____
(Prescriber must include documentation of insufficient response(s) to other medication(s) used for LGS with this fax)

PRESCRIBER INFORMATION

Name (print):_____   **NPI Number:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___   **Fax Number**: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Signature of Prescribing Provider: _____

PLEASE INCLUDE ALL REQUESTED INFORMATION
INCOMPLETE FORMS WILL DELAY THE PRIOR AUTHORIZATION PROCESS

FAX TO 800-932-6651
SERVICE AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE AND THUS DRUG COVERAGE
http://www.virginiamedicaidpharmacyservices.com